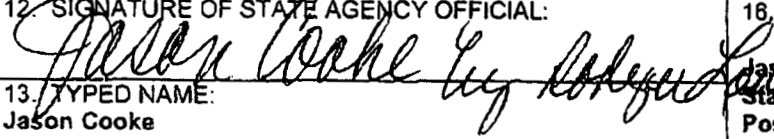



DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATIONFORM APPROVED
OMB NO. 0938-0193

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| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION | | 1. TRANSMITTAL NUMBER: 03 - 15 | 2. STATE: TEXAS |
| | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 4. PROPOSED EFFECTIVE DATE: September 1, 2003 | |
| 5. TYPE OF PLAN MATERIAL (Circle One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT | | | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) | | | |
| 6. FEDERAL STATUTE/REGULATION CITATION: | | 7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 04 \$ (205,870,001) b. FFY 05 \$ (196,033,272) | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT | |
| 10. SUBJECT OF AMENDMENT: This amendment eliminates recalculating the standard dollar amount (SDA) and the cost-of-living update factor applied to the SDA of all hospitals for inpatient hospital admissions during state fiscal years 2004 and 2005. The amendment revises the high volume adjustment factors applied to the SDA of certain hospitals for inpatient admissions during state fiscal years 2004 and 2005. This amendment will also, allow certain Medicaid hospitals with more than 100 licensed beds the option of receiving cost-based reimbursement authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Lastly this amendment modifies the reimbursement for direct graduate medical education for admission during state fiscal years 2004 and 2005. | | | |
| 11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Sent to Governor's Office this date. Comments, if any, will <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL be forwarded upon receipt. | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL:  | | 16. RETURN TO: Jason Cooke State Medicaid/CHIP Director Post Office Box 13247 Austin, Texas 78711 | |
| 13. TYPED NAME: Jason Cooke | | | |
| 14. TITLE: State Medicaid/CHIP Director | | | |
| 15. DATE SUBMITTED: September 19, 2003 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: SEP 23 2003 | | 18. DATE APPROVED: APR 5 2004 | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP - 1 2003 | | 20. SIGNATURE OF REGIONAL OFFICIAL:  | |
| 21. TYPED NAME: Charlene Brown | | 22. TITLE: Regional Director, CMSA | |
| 23. REMARKS: | | | |

The LOS is the lesser of the DRG mean LOS, the claim LOS, or 30 days. The 30-day factor is not used in establishing a DRG per diem amount for a medically necessary stay of a recipient less than age 21 in compliance with the EPSDT provisions of the Omnibus Budget Reconciliation Act of 1989 and the provisions of Section 4604 of the Omnibus Budget Reconciliation Act of 1990.

(3) If the state agency or its designee determines that the transferring hospital provided a greater amount of care than the receiving hospital, the state agency or its designee reverses the payment amounts. The transferring hospital is paid the total payment amount of the patient's DRG and the receiving hospital is paid the DRG per diem.

(4) The state agency or its designee makes multiple transfer payments by applying the per diem formula to the transferring hospitals and the total DRG payment amount to the discharging hospital.

(g) Split billing. The state agency or its designee does not allow interim billings by providers. The hospital may bill the state agency or its designee when the patient exceeds his 30-day inpatient hospital limit or is discharged. The state agency or its designee bases payment on the diagnosis codes known at billing. The payment is final.

(h) Rebased the standard dollar amounts. The state agency or its designee rebases the standard dollar amount for each payment division at least every three years. The state agency will not rebase or recalculate the standard dollar amounts for each payment division for admissions during the period September 1, 2003 through August 31, 2005. The relative weights are recalibrated whenever the standard dollar amounts are recalculated. The standard dollar amounts are not rebased on an interim basis unless the state agency or its designee determines that special circumstances warrant rebasing.

(i) Recalibrating the relative weights. The state agency or its designee recalibrates the relative weights whenever the standard dollar amounts are rebased or recalibrated.

(j) Revising the diagnosis related groups. The state agency or its designee parallels the taxonomy of diagnoses as defined in the Medicare DRG prospective payment system unless a revision is required based on Texas claims data or other factors as determined by the state agency or its designee.

(k) Appeals.

(1) A hospital may appeal individual claims as specified in other sections of this State Plan. As specified in subparagraphs (A), (B), and (C) of this paragraph, a hospital may also appeal mechanical, mathematical, and data entry errors in base year claims data and incorrectly computed subsequent adjustments to the hospital's base year claims data because of the base year's tentative or final settlement.

(A) If a hospital believes that the state agency or its designee made a mechanical, mathematical, or data entry error in computing the hospital's base year claims data, the hospital may request a review of the disputed calculation by the state agency or, at the state agency's direction, its designee. A hospital may not request a review if the disputed calculation is the result of the hospital's submittal of incorrect data or the result of the state agency's or its designee's application of an interim rate to the base year claims data derived from a cost reporting period occurring before the base year. Upon the provider hospital's request, the state agency or its designee provides the applicable available data used in calculating the hospital's base year claims data to the provider hospital. The hospital must submit a specific written request for review and appropriate specific documentation supporting

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(B) If a review or appeal of a tentative or final settlement is not completed at least 60 days before the beginning of the next prospective year, the interim rate applied to the claims data on which the hospital's payment division and standard dollar amount are established is the interim rate established at tentative or final settlement by the state agency or its designee. Any adjustment required after the completion of the review or appeal is applied only to the subsequent prospective year.

(C) The state agency or its designee makes a March 1, 1988, adjustment to each hospital's 1985 base year claims data and resulting payment division and standard dollar amount to reflect the interim rate established at tentative and final settlement, if applicable, of the cost reporting period associated with the 1985 base year. Any additional adjustments required as the result of reviews and appeals described in subsection (k) of this section and completed by December 31, 1987, are also reflected in the March 1, 1988, adjustment. Future adjustments as described in this subsection and subsection (k) of this section are made at the beginning of each prospective year.

(2) The state agency or its designee updates the standard dollar amount each year for each payment division by applying a cost-of-living index to the standard dollar amount established for the base year. The cost-of-living update for state fiscal year 2003, 2004, and 2005 will not be applied to the standard dollar amount for admissions during the period September 1, 2002 through August 31, 2005. The index used to update the standard dollar amounts is the greater of:

(A) the Health Care Financing Administration's (HCFA) Market Basket Forecast (PPS Hospital Input Price Index) based on the report issued for the federal fiscal year quarter ending in March of each year, adjusted for the state fiscal year by summing one-third of the annual forecasted rate of the index for the current calendar year and two-thirds of the annual forecasted rate of the index for the next calendar year; or

(B) an amount determined by selecting the lesser of the following two measures:

(i) the change in total charges per case for the latest year available compared to total charges per case for the previous year; or

(ii) the change in the Texas medical consumer price index-urban (that is, the arithmetic mean of the Houston and Dallas/Fort Worth medical consumer price indexes for urban consumers) for the latest year available compared to the Texas medical consumer price index-urban for the previous year.

(0) Reimbursement to in-state children's hospitals. The state agency or its designee reimburses in-state children's hospitals under similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248, Tax Equity and Fiscal Responsibility Act (TEFRA). The state agency or its designee establishes target rates and stipulates payments per discharge, incentives, and percentage of payments. The state agency or its designee uses each hospital's 1987 final audited cost reporting period (fiscal year ending during calendar year 1987) as its target base period. The target base period for hospitals recognized by Medicare as children's hospitals after the implementation of this subsection is the hospital's first full 12-month cost reporting period occurring after its recognition by Medicare. The state agency or its designee annually increases each hospital's target amount for the target base period by the cost-of-living index described in subsection (n) of this section. The state agency or its designee selects a new target base period at least every three years. In compliance with the EPSDT requirements of the Omnibus Budget Reconciliation Act of 1989 to provide other necessary health care and the provisions of Section 4604 of the Omnibus Budget Reconciliation Act of 1990, the costs of services provided to Medicaid-eligible individuals under age 21 are treated as pass-through cost and are calculated.

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(q) Hospitals with 100 or fewer licensed beds and certain hospitals with more than 100 licensed beds. The policies in this subsection apply only to hospital fiscal years beginning on or after September 1, 1989 for hospitals with 100 or fewer licensed beds at the beginning of the hospital's fiscal year or hospital fiscal years beginning on or after September 1, 2003 for hospitals with more than 100 licensed beds at the beginning of the hospital's fiscal year, located in a county that is not in a metropolitan statistical area (MSA) as defined by the U.S. Office of Management and Budget (OMB) and designated by the Center for Medicare & Medicaid Services as a Sole Community Provider (SCH) or Rural Referral Center RCC. At tentative cost settlement of the hospital's fiscal year (with subsequent adjustment at final cost settlement, if applicable), the HHSC or its designee determines what the amount of reimbursement during the fiscal year would have been if the HHSC or its designee reimbursed the hospital under similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248, Tax Equity and Fiscal Responsibility Act (TEFRA). This determination is made without imposing a TEFRA cap. If the amount of reimbursement under the TEFRA principles is greater than the amount of reimbursement received by the hospital under the prospective payment system, the HHSC or its designee reimburses the difference to the hospital.

(r) Reimbursement to out-of-state children's hospitals. For admissions on or after September 1, 1991, the standard dollar amount for out-of-state children's hospitals is calculated as specified in this subsection. The state agency or its designee calculates the overall average cost per discharge for in-state children's hospitals based on tentative or final settlement of cost reporting periods ending in calendar year 1990. The overall average cost per discharge is adjusted for intensity of service by dividing it by the average relative weight for all admissions from in-state children's hospitals during state fiscal year 1990 (September 1, 1989 - August 31, 1990). The adjusted cost per discharge is updated each year as additional final settlements are completed using the time frames described in subsection (n) of this section and by applying the cost-of-living index described in subsection (n) of this section. The resulting product is the standard dollar amount to be used for payment of claims as described in subsection (e) of this section. The state agency or its designee selects a new cost reporting period and admissions period from the in-state children's hospitals at least every three years for the purpose of calculating the standard dollar amount for out-of-state children's hospitals.

(s) Reimbursement of inpatient direct graduate medical education (GME) costs. The Medicaid allowable inpatient direct graduate medical education cost, as specified under similar methods and procedures used in the Social Security Act, Title XVIII, as amended, effective October 1, 1982, by Public Law 97-248, is calculated for each hospital having inpatient direct graduate medical education costs on its tentative or final audited cost report. Those inpatient direct medical education costs are removed from the calculation of the interim rate described in subsection (b)(7) of this section and not used in the calculation of the provider's standard dollar amount described in subsection (c) of this section. Those allowable inpatient direct graduate medical education costs for services delivered to Medicaid eligible patients with inpatient admission dates on or after September 1, 1997, will be subject to the cost determination and settlement provisions as described in this subsection. No Medicaid inpatient direct graduate medical education cost settlement provisions are applied to inpatient hospital admissions prior to September 1, 1997.

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(t) Non-State Owned Urban Public Hospital Supplemental Inpatient Payments.

Notwithstanding other provisions of this attachment, supplemental payments will be made each state fiscal year in accordance with this subsection to eligible hospitals that serve high volumes of Medicaid and uninsured patients.

(1) Supplemental payments are available under this subsection for inpatient hospital services provided by a non-state owned or operated publicly-owned hospital or hospital affiliated with a hospital district in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis on or after July 6, 2001.

(2) The supplemental payments described in this subsection will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 C.F.R. §447.272. The following method is used to reasonably estimate the Medicaid upper limit. Medicare payments subject to case mix adjustment are divided by a hospital's Medicare case mix index (CMI) to determine total Medicare payments for case mix of 1.0. Medicare pass-through payments are added, and the total is divided by Medicare discharges in order to determine a Medicare CMI adjusted payment per discharge. Medicaid payments subject to case mix adjustment are divided by a hospital's Medicaid CMI to determine total Medicaid payments for a case mix of 1.0. Medicaid pass-through payments are added, and the total is divided by Medicaid discharges in order to determine a Medicaid CMI adjusted payment per discharge. The Medicaid CMI adjusted payment per discharge is subtracted from Medicare CMI adjusted payment per discharge. The result is multiplied by the hospital's base year Medicaid CMI to determine a CMI adjusted Medicaid Medicare payment per discharge differential. This payment per discharge differential is multiplied by Medicaid base year discharges and inflated to the current period. The calculation uses base year paid Medicaid claims and cost reports. All managed care patients excluded from the calculation.

(3) In each county listed in paragraph (t)(1) of this section, the publicly-owned hospital or hospital affiliated with a hospital district that incurs the greatest amount of cost for providing services to Medicaid and uninsured patients, will be eligible to receive supplemental high volume payments. The supplemental payments authorized under this subsection are subject to the following limits:

- (A) In each state fiscal year the amount of any inpatient supplemental payments and outpatient supplemental payments may not exceed the hospital's "hospital specific limit," as determined under Appendix I to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals (DSH)); and
- (B) The amount of inpatient supplemental payments and fee-for-service Medicaid inpatient payments the hospital receives in a state fiscal year may not exceed Medicaid inpatient billed charges for inpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 CFR §447.271.

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(4) An eligible hospital will receive quarterly supplemental payments. The quarterly payments will be one-fourth of the lesser of:

- (A) The difference between the hospital's Medicaid inpatient billed charges and Medicaid payments the hospital receives for services provided to fee-for-service Medicaid recipients. Medicaid billed charges and payments will be based on a twelve consecutive-month period of fee-for-service claims data selected by the state agency; or
- (B) The difference between the hospital's "hospital specific limit," as determined under Appendix I to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals (DSH)) and the hospital's DSH payments as determined by the most recently finalized DSH reporting period.

(5) For purposes of calculating the "hospital specific limit" under this subsection, the "cost of services to uninsured patients" and "Medicaid shortfall", as defined by Appendix I to Attachment 4.19-A, the amount of Medicaid payments (including inpatient and outpatient supplemental payments) that exceed Medicaid cost will be subtracted from the "cost of services to uninsured patients" to ensure that during any state fiscal year, a hospital does not receive more in total Medicaid payments (inpatient and outpatient rate payments, graduate medical education payments, supplemental payments and disproportionate share hospital payments) than their cost of serving Medicaid patients and patients with no health insurance.

(u) In accordance with other provisions of this attachment, a high volume adjustment factor will be included in the calculation of the state fiscal year 2003, 2004, and 2005 (September 1, 2002 through August 31, 2005) standard dollar amount as described in subsection (a)(4) of this section.

(1) Eligible Hospitals. All non-state owned or operated, non public, DRG reimbursed hospitals located in urban counties with a population greater than 100,000, and Medicaid days greater than 175% of the mean Medicaid days in the base period will be eligible for a high volume adjustment to their standard dollar amount. The base period for determining the mean Medicaid days and hospitals eligible for the high volume adjustment to the standard dollar amount in state fiscal year 2003 is state fiscal year 2001 (September 1, 2000 through August 31, 2001). The base period for determining the mean Medicaid days and hospitals eligible for the high volume adjustment to the standard dollar amounts in state fiscal year 2004 and 2005 is state fiscal year 2002 (September 1, 2001 through August 31, 2002). Medicaid days will be based on hospital claims data selected by HHSC. County population will be based on the 2000 United States census.

(2) All eligible hospitals in counties with a population less than 1,000,000 will receive a high volume adjustment factor of 6.50% for state fiscal year 2003 and a high volume adjustment factor of 3.25% for state fiscal years 2004 and 2005; eligible hospitals in counties with a population greater than 1,000,000 will receive a high volume adjustment factor of 10.25% for state fiscal year 2003 and a high volume adjustment factor of 3.25% for state fiscal years 2004 and 2005.

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(v) Non-State Owned Rural Public Hospital Supplemental Inpatient Payments. Notwithstanding other provisions of this attachment, supplemental payments will be made each state fiscal year in accordance with this subsection to eligible rural public hospitals for inpatient services provided to Medicaid patients.

(1) For purposes of this subsection, rural public hospital means a public hospital affiliated with a city, county, hospital authority, or hospital district located in a county of less than 100,000 population based on the most recent federal decennial census.

(2) The supplemental payments described in this subsection will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 C.F.R. §447.272 and shall not exceed \$35,000,000 per state fiscal year. The following method is used to reasonably estimate the Medicaid upper limit. Medicare payments subject to case mix adjustment are divided by a hospital's Medicare case mix index (CMI) to determine total Medicare payments for case mix of 1.0. Medicare pass-through payments are added, and the total is divided by Medicare discharges in order to determine a Medicare CMI adjusted payment per discharge. Medicaid payments subject to case mix adjustment are divided by a hospital's Medicaid CMI to determine total Medicaid payments for a case mix of 1.0. Medicaid pass-through payments are added, and the total is divided by Medicaid discharges in order to determine a Medicaid CMI adjusted payment per discharge. The Medicaid CMI adjusted payment per discharge is subtracted from Medicare CMI adjusted payment per discharge. The result is multiplied by the hospital's base year Medicaid CMI to determine a CMI adjusted Medicaid Medicare payment per discharge differential. This payment per discharge differential is multiplied by Medicaid base year discharges and inflated to the current period. The calculation uses base year paid Medicaid claims and cost reports. All managed care patients excluded from the calculation.

(3) The amount of supplemental payments and fee-for-service Medicaid inpatient payments (including DRG and TEFRA inpatient cost settlements) the hospital receives in a state fiscal year may not exceed Medicaid inpatient billed charges for inpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 CFR §447.271.

(4) Supplemental payments will be made to two groups of rural public hospitals.

- (A) Rural public hospitals that have a deficit between fee-for-service Medicaid billed charges and fee-for-service Medicaid payments (including supplemental payments) greater than 1 percent of the total deficit between fee-for-service Medicaid billed charges and fee-for-service Medicaid payments (including supplemental payments) for all rural public hospitals. Medicaid billed charges and payments will be based on a twelve consecutive-month period of fee-for-service claims data selected by HHSC.
- (B) All other rural public hospitals that have a deficit between fee-for-service Medicaid billed charges and fee-for-service Medicaid payments (including supplemental payments). Medicaid billed charges and payments will be based on a twelve consecutive-month period of fee-for-service claims data selected by HHSC.

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(5) Supplemental payments will be made quarterly to rural public hospitals that have a deficit between fee-for-service Medicaid billed charges and fee-for-service Medicaid payments (including supplemental payments).

(A) Hospitals eligible for payments according to section (v)(4)(A), the amount of the quarterly supplemental payments will be one-fourth of:

- (1) The amount determine by multiplying the current state fiscal year Federal Medical Assistance Percentage (FMAP) by the deficit between fee-for-service Medicaid billed charges and fee-for-service Medicaid payments (including supplemental payments),
- (2) The hospital's pro rata share of the amount available to be distribute after subtracting payments to hospitals according to section (v)(A)(1). Hospitals eligible for payments according to section (v)(4)(B), the amount of the supplemental payments will be one-fourth of the hospital's pro rata share of the amount available to be distribute after subtracting payments to hospitals according to section (v)(5)(A)(1).

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